

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08507

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b> c. LENGTH OF STAY IN 1b <b>4 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, write place of death) <b>MEMORIAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROUTE # 2 WILLIAMS ROAD</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>ELIZABETH</b> Last <b>ABE.</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>28</b> Year <b>19 60</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-24-1887</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. UNDER 1 YEAR <b>10 4</b> Months Days		11. UNDER 24 HRS. <b>10 4</b> Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
13. FATHER'S NAME <b>GEORGE W. GLOYD</b>				14. MOTHER'S MAIDEN NAME <b>JENNY LARGENT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute peripheral vascular collapse</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>Arteriosclerotic heart disease</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Partial intestinal obstruction. Etiology unknown</b> INTERVAL BETWEEN ONSET AND DEATH <b>Since 2/11/50</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-11-</b> 19 <b>50</b> to <b>8-28-</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>8-28-</b> 19 <b>60</b> and that death occurred <b>5:48 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Fred Williams</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8-20-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. FRED WILLIAMS</b>				22d. ADDRESS <b>122 SOUTH CENTRE ST. CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/31/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Little Cacapon Forks</b>		23d. LOCATION (City, town, or county) (State) <b>Paw Paw, Hampshire W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hume</b>				25a. REC'D BY REGISTRAR <b>W. Va.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	

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ROBERT S WILLIAMS ROAD

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8628

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08608

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>40 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give place of death) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>PAW PAW</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>85X-3</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>ALLEN</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>3</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-20-1891</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.		IF UNDER 24 HRS. Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>PAW PAW, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FELTON ALLEN</b>				14. MOTHER'S MAIDEN NAME <b>LIZA BOOR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>235-14-2056</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardiovascular disease</b> 422.1 DUE TO (b) <b>Vasculostasis</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause last. (c) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-2-60</b> to <b>8-3-60</b> and that death occurred on <b>8-3-60</b> at <b>5:50 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W.F. Williams</b>		22b. DATE SIGNED <b>8-4-60</b>		22c. PHYSICIAN'S NAME (Type) <b>W.F. WILLIAMS</b>		22d. ADDRESS <b>122 SOUTH CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Aug. 6, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodrow Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Paw Paw, (Morgan) W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>PARKS FUNERAL HOME, Berkeley Spgs. W. Va.</b>				25a. REC'D BY REGISTRAR <b>AUG 15 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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08088

CERTIFICATE OF DEATH

8528



WEST VIRGINIA

10 DAYS

OUTER CASE

JOHN & MARY

WILLIAM

ALICE

JOHN

WHITE

WIFE

Laborer

U. S. Steel Co.

1151 W. 10th

ELTON ALEX

852-14-8056 WESTERN HOSPITAL, GREENLAND, W.V.

NO

CERTIFICATE OF DEATH

125 SOUTH CENTRE ST., GREENLAND, W. VA.

Box 144, (Greenland) W. Va.

Aug. 6, 1960 Woodrow Tom.

Funeral

Funeral Home, Berkeley Spgs, W. Va.

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VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8629

CERTIFICATE OF DEATH

Reg. Dist. No. 08609

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ALLEGANY</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>12 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>	
		d. STREET ADDRESS <u>211 FULTON ST.</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>LOUIS</u> Middle <u>RILEY</u> Last <u>BAKER</u>		<b>4. DATE OF DEATH</b> Month <u>AUGUST</u> Day <u>1</u> Year <u>19 60</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 1, 1901</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storeroom</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KELLY SPRINGFIELD TIRE CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mt/Savage</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ARTHUR BAKER (DECEASED)</u>		14. MOTHER'S MAIDEN NAME <u>MARY BRIDGES (DECEASED)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-7057</u>	
17. INFORMANT <u>PATIENTS CHART</u>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis - generalized</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Congestive Heart Failure - Unremitting - Peripheral Vasc. Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/18</u> , 19 <u>60</u> , to <u>8/1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/31</u> , 19 <u>60</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>441 N. CENTRE ST., CUMBERLAND, MD.</u> DATE SIGNED <u>8/2/60</u>			
ACTUAL SIGNATURE <u>William P. James</u> M.D.			
PHYSICIAN'S NAME (Type) <u>WILLIAM P. JAMES, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 4, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Savage Methodist Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Savage, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>AUG 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hafer</u>	

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VR A15 (4)  
15M 9/59

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8630

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08610

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>7/6/60</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. STREET ADDRESS <b>789 Fayette Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>Allen</b> Last <b>Birchard</b>		4. DATE OF DEATH Month <b>August</b> Day <b>31</b> , Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/15/1872</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months <b>87</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Allen</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hambricht</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O. Box 599</b> <b>Allegany County Infirmary Records</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hypostasis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocardial Degeneration</b> (c) <b>Cerebral Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b> <b>?</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/6/60</b> to <b>8/31/60</b> , that (I) (we) last saw the deceased alive on <b>8/31/60</b> , and that death occurred at <b>6:15 P.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. McLean</b>		22b. DATE SIGNED <b>9/1/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 3, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 6 '60</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

CERTIFICATE OF DEATH

8830

Allegheny

Maryland

Allegheny

Cumberland

7/6/60

Cumberland

787 Rayces Street

Allegheny County Infirmary

Age 37

Richard

Alton

Female

37

11/15/1872

2

White

Female

U. S. A.

Cumberland, Maryland

and

Homewite

Mary Remington

William Alton

Cumberland, Md.

P.O. Box 299

Allegheny County Infirmary Records

*[Faint, illegible handwritten text]*

7/21/60

7/6/60

7/31/60

7/1/60

777 Stone St., Cumberland, Md.

Dr. James E. Nelson



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8672

08611

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>1 Month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Seggie</b> Last <b>Boettcher</b>		4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 27, 1881</b>
9. AGE (In years lost birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Seggie</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Lindsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>William Boettcher</b>	
17. INFORMANT <b>Lonaconing, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>"Son"</b> <b>443 X</b> DUE TO <b>Hypertensive Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 1959</b> to <b>AUG. 14, 1960</b> , that (I) (we) last saw the deceased alive on <b>AUG. 14, 1960</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>MARTIN M. ROTHSTEIN M.D.</b>		22b. DATE SIGNED <b>8/16/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN M.D.</b>		22d. ADDRESS <b>48 BROADWAY - FROSTBURG - MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/17/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 22 '60</b>	
ADDRESS <b>Lonaconing, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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1. *Staphylococcus aureus*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

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8631 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08612  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GERTHA VIRGINIA BOORE		4. DATE OF DEATH Month Day Year AUGUST 17, 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 25, 1895
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - CLERK		10b. KIND OF BUSINESS OR INDUSTRY AMERICAN STORES CORPORATION	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS JENKINS (DECEASED)		14. MOTHER'S MAIDEN NAME GERTHA NIXON (DECEASED)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-22-2637	
17. INFORMANT Address RAYMOND BOORE, MT. SAVAGE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3-4 HRS.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-20-60	
22c. NAME OF CEMETERY OR CREMATORY St. George Cemetery		22d. LOCATION (City, town, or county) (State) MT. SAVAGE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Swart		ADDRESS FROSTBURG, MD.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE AUG 19 '60			

# STATE DEPARTMENT OF HEALTH - BATHING IN MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION	

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8632

**CERTIFICATE OF DEATH**

**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

08613

1. PLACE OF DEATH o. COUNTY <b>ALLEHANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEHANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>8 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>229 National Highway, LaVale</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ORRLE</b> Middle <b>B.</b> Last <b>BOUGHTON</b>				4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/13/76</b>	9. AGE (In years lost birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher-- Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William G. Boughton (d)</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Parker Boughton (d)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Old Chart</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA-- BILATERAL</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MEDIASTINAL CARCINOMA.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. Bauer MD</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9-2-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. Bauer</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 2, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 6 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After a death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed in the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08614

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MINERS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>JOSEPH</b> Last <b>BRADY</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>15</b> , Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 16, 1900</b>
9. AGE (In years lost birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PBGH. COKE &amp; CHEM. Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS BRADY</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE MORAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>172-20-4820</b>	
17. INFORMANT <b>Francis Brady,</b>		Address <b>Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial insufficiency</b> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 wks</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 30, 1960</b> to <b>Aug 15, 1960</b> that (I) (we) last saw the deceased alive on <b>Aug 5, 1960</b> and that death occurred at <b>1:15</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>W. O. McLane M.D.</b>		22b. DATE SIGNED <b>Aug 16, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>		22d. ADDRESS <b>E. MAIN ST., FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-18-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst</b>		25a. REC'D BY REGISTRAR <b>AUG 18 60</b>	
ADDRESS <b>FROSTBURG, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

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*[Faint, illegible handwriting and text, possibly bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08615

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>CUMBERLAND,</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND MD.</b>				c. LENGTH OF STAY IN 1b <b>27 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GLADYS</b> Middle <b>Myrtle</b> Last <b>BRELSFORD</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 29, 1902</b>		9. AGE (In years last birthday) <b>57 yrs.</b>	10. IF UNDER 1 YEAR Months <b>57</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tuber ( Tube room )</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly-Tire Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Cold Stream, W.VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM BRELSFORD</b>				14. MOTHER'S MAIDEN NAME <b>Sydney RICHMOND</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>				16. SOCIAL SECURITY NO. <b>214-07-0958</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>8 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>62 GREENE ST., CUMBERLAND, MD.</b>	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>2 - 13</b> 19 <b>54</b> to <b>8 - 1</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>8 - 1</b> 19 <b>60</b> and that death occurred at <b>3:10 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>DR. BALLIN</b>				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8-2-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. BALLIN</b>				22d. ADDRESS <b>62 GREENE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/4/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 5 60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

MEDICAL CERTIFICATION

08813

CERTIFICATE OF DEATH

8832



ALBERTA, CANADA, DISTRICT OF ALBERTA, COUNTY OF ALBERTA, CITY OF CALGARY

DECEASED, I hereby certify that on the 27th day of

1913, at the residence of the deceased, in the City of Calgary, Alberta, Canada, the following named person

namely, JOHN J. HARRIS, of the County of Calgary, District of Alberta, Province of Alberta, Canada, died

at the residence of the deceased, in the City of Calgary, Alberta, Canada, at the age of 45 years

and that the death was caused by heart disease, the result of old age, and that the deceased was

at the time of death, in the full possession of his mind and faculties, and that the death was

not caused by any violence, fraud, or other unlawful means, and that the deceased was not

at the time of death, suffering from any mental or physical disease, or from any other

condition, which would render the death suspicious, and that the death was

not caused by any other person, and that the death was not caused by any

other person, and that the death was not caused by any other person, and that the death was

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8634  
CERTIFICATE OF DEATH

08616

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>15 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, address, OR INSTITUTE) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVE.,</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>43 WESTERNPORT</b>			
d. STREET ADDRESS <b>1 302 SPRUCE ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>C.</b> Last <b>BROADWATER</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>22</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 30, 1892</b>	
9. AGE (In years lost birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.		IF UNDER 24 HRS. Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>ARCHIBALD BROADWATER</b>				14. MOTHER'S MAIDEN NAME <b>CLARA WAMPLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>1</b>				16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Heart failure</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive and arteriosclerotic Cardio-vascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks</b> <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>7 Aug 1960</b> to <b>22 Aug 1960</b> , that (I) (we) last saw the deceased alive on <b>22 Aug 1960</b> , and that death occurred at <b>11:25 PM</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>W. Alfred Van Ormer</b>				22b. DATE SIGNED <b>23 Aug 60</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>				22d. ADDRESS <b>122 S. CENTRE ST. CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>8/26/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cem.</b>	
23d. LOCATION (City, town, or county) (State) <b>Westernport MD.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. S. Boal</b>				25a. REC'D BY REGISTRAR <b>Aug 29 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

08610

8634  
CERTIFICATE OF DEATH  
DEPARTMENT OF HEALTH  
STATE OF NEW YORK



ALLGAIN  
CUMBERLAND  
15 DAYS  
MEMORIAL HOSPITAL  
BAMMICK & BRILL AVE.  
BIRMINGHAM  
BROWDER  
JANUARY 30, 1945  
WHITE  
CLARA WAMLER  
RICHARD BROWDER  
MARYLAND  
U. S. A.

MEMORIAL HOSPITAL-CUMBERLAND, MD.

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document.]*



155 S. CENTRE ST., CUMBERLAND, MD.  
1/25/45  
1/25/45  
1/25/45



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08617

8635

Item 4 Film G270 9-6-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		d. STREET ADDRESS <b>808 Buckingham Road.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George L. Buchanan</b>		4. DATE OF DEATH Month Day Year <b>August 26 21, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26 1893</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pres. of Buchanan Lumber Co. Lumber</b>	
11. BIRTHPLACE (State or foreign country) <b>Ellerslie Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard Buchanan</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Rhodes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>L. Leslie Helmer Cumberland Md.</b>	
17. INFORMANT <b>L. Leslie Helmer Cumberland Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTRACRANIAL HEMORRHAGE;</b> <b>902.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>MACERATION OF BRAIN</b> (c) <b>SKULL FRACTURE</b> DUE TO stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>4 Hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from cliff about 60 feet high</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>9:00 Aug. 21 1960</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> <b>Summer Home</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>5 Mi. S. Romney Hampshire, W. Va.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>August 21, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 23, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. H. Inc. Cumberland Md</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE AUG 24 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Orin L. H. H.</b>	

08817

STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08832

NAME OF DECEASED		SEX		AGE	
JAMES H. HANCOCK		MALE		45	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAN. 20 1913		HOSPITAL		HEART DISEASE	
TIME OF DEATH		PLACE OF BURIAL		MANNER OF DEATH	
10:15 P.M.		CATHOLIC CEMETERY		NATURAL	
SIGNATURE OF EXAMINER		SIGNATURE OF ATTENDING PHYSICIAN		SIGNATURE OF CLERK	
J. H. HANCOCK		J. H. HANCOCK		J. H. HANCOCK	
DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION	
JAN. 20 1913		JAN. 20 1913		JAN. 20 1913	
TIME OF EXAMINATION		TIME OF EXAMINATION		TIME OF EXAMINATION	
10:15 P.M.		10:15 P.M.		10:15 P.M.	
PLACE OF EXAMINATION		PLACE OF EXAMINATION		PLACE OF EXAMINATION	
HOSPITAL		HOSPITAL		HOSPITAL	
CITY		CITY		CITY	
BOSTON		BOSTON		BOSTON	
STATE		STATE		STATE	
MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS	
COUNTY		COUNTY		COUNTY	
SUFFOLK		SUFFOLK		SUFFOLK	
TOWN		TOWN		TOWN	
DORCHESTER		DORCHESTER		DORCHESTER	
WARD		WARD		WARD	
1		1		1	
BLOCK		BLOCK		BLOCK	
1		1		1	
LOT		LOT		LOT	
1		1		1	
DECEASED'S RESIDENCE		DECEASED'S RESIDENCE		DECEASED'S RESIDENCE	
1234 BROADWAY		1234 BROADWAY		1234 BROADWAY	
CITY		CITY		CITY	
BOSTON		BOSTON		BOSTON	
STATE		STATE		STATE	
MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS	
COUNTY		COUNTY		COUNTY	
SUFFOLK		SUFFOLK		SUFFOLK	
TOWN		TOWN		TOWN	
DORCHESTER		DORCHESTER		DORCHESTER	
WARD		WARD		WARD	
1		1		1	
BLOCK		BLOCK		BLOCK	
1		1		1	
LOT		LOT		LOT	
1		1		1	

RECEIVED  
JAN 21 1913  
BUREAU OF  
MEDICAL EXAMINER'S  
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8636

## CERTIFICATE OF DEATH

08618

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegheny</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegheny</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>4yrs. 3mos. 3wks.</b> 02 <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		d. STREET ADDRESS <b>1 12 Fifth Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Elmer</b> Last <b>Burke</b>		4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/12/75</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sand &amp; Gravel</b>	
11. BIRTHPLACE (State or foreign country) <b>Co Pennsylvania Tyrone</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Burke</b>		14. MOTHER'S MAIDEN NAME <b>Mary unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Stanley Burke</b>		Address <b>I2 5th St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420 Chronic myocardial degeneration</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. <b>430 cerebral arteriosclerosis,</b> <b>440 coronary sclerosis,</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>082 Acute Encephalitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr. 17th, 1956</b> to <b>Aug. 9th, 1960</b> , that I last saw the deceased alive on <b>Aug. 8th, 1960</b> , and that death occurred at <b>3:30 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>49 Greene St.,</b> DATE SIGNED <b>8-9-60</b>	
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.			
PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b>		<b>49 Greene St., Cumberland, Allegheny Co., Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-10-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 16 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8683

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Savage</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>LYNN</b> Last <b>BUTLER</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 25, 1931</b>	
9. AGE (In years last birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months <b>29</b> Days <b>29</b> Hours <b>29</b> Min.		IF UNDER 24 HRS. Months <b>29</b> Days <b>29</b> Hours <b>29</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>McGREEVY TRANS. CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>DANIEL BUTLER</b>				14. MOTHER'S MAIDEN NAME <b>ELSIE SHAFFER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WW 2</b>				16. SOCIAL SECURITY NO. <b>218-24-8694</b>		17. INFORMANT <b>Mrs. Elsie Butler, Mt. Savage, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TRAUMATIC ASPHYXIATION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CRUSHED CHEST AND ABDOMEN</b> DUE TO (c) <b>II</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3-5 Minutes.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was Run over By His own Car</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>8:45</b> a.m. <b>Aug 19 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>His yard</b>		20f. (City or town) (County) (State) <b>Mountsavage Allegany Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>W.O. McLane</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>W.O. McLane</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
Asst. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>August 16, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUG. 19 '60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>METHODIST CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MT. SAVAGE, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Burst</b>				ADDRESS <b>FROSTBURG, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 19 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			

MEDICAL CERTIFICATION







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8637

08620

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>3 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>402 Furnace Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Jane</b> Last <b>Collins</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 21, 1871</b>	
9. AGE (In years lost birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>26</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>8</b> Days <b>26</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Rader</b>				14. MOTHER'S MAIDEN NAME <b>Minerva McClane</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Ruth Carr LaVale, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO <b>422-2</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>10 years</b> (c)				INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 26 1960</b> to <b>August 26 1960</b> that (I) (we) last saw the deceased alive on <b>August 26 1960</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>F. F. Broadup</b>				22b. ADDRESS <b>Cumberland Md.</b>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/29/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Goldizen Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Jorden Run, W Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				ADDRESS <b>Cumberland Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 31 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

3648

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

8638

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN lb <u>50 YEARS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>645 COLUMBIA AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>E.</u> Last <u>COLOMY</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>27</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 25, 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SIGN PAINTING</u>		11. BIRTHPLACE (State or foreign country) <u>MAINE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WALTER COLOMY</u>				14. MOTHER'S MAIDEN NAME <u>CLARA ANDERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220 16 6547</u>		17. INFORMANT <u>MRS. WM. F. COWHERD</u> Address <u>CUMBERLAND, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>AUGUST " 27, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 30, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST BURIAL PARK</u>		22d. LOCATION (City, town, or county) (State) <u>CUMBERLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BYRON KIGHT</u>				ADDRESS <u>CUMBERLAND, MD,</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Howard</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Board of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8680

08622

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				c. LENGTH OF STAY IN 1b <b>X</b> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Detmold Street</b>				d. STREET ADDRESS <b>1 Detmold Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Wilda</b> Middle <b>Isabelle</b> Last <b>Dawson</b>				4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 13, 1913</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>17</b> Hours <b>47</b> Min.		11. IF UNDER 24 HRS. Months <b>4</b> Days <b>17</b> Hours <b>47</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Clarence McKenzie</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Dunn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Homer Dawson</b> Address <b>Lonaconing, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>416X Coronary Thrombosis</b> DUE TO (b) <b>Rheumatic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Lonaconing, Md.</b>	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1956</b> to <b>Aug. 6, 1957</b> , that (I) (we) last saw the deceased alive on <b>1957</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Smiles J. M.D.</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8-6-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>				22d. ADDRESS <b>LONACONING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/10/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 9 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

0800

0800

CERTIFICATE OF DEATH

Allegation

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**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

08623

8639

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>1 526 GREENE ST.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>LEO</b> Last <b>DENSON</b>				4. DATE OF DEATH Month <b>AUG.</b> Day <b>3</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 27, 1882</b>		9. AGE (In years lost birthday) yrs. <b>78</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>SAMUEL DENSON (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>MERRISH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-2</b> 19 <b>58</b> to <b>8-3</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>8-3</b> 19 <b>60</b> , and that death occurred at <b>8:50AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Brings</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS, MD</b>				22d. ADDRESS <b>57 GREENE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/6/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Travis Stein Inc. Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

08830

CERTIFICATE OF DEATH

08830



1



11/15/45

11/15/45

11/15/45

**MARYLAND STATE BOARD OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08624

8640

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>E</b> Last <b>DE VORE</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 22, 1888</b>	
9. AGE (In years lost birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED WATCHMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R.R.CO.</b>			
11. BIRTHPLACE (State or foreign country) <b>CORRIGANVILLE, MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JESS DE VORE</b>				14. MOTHER'S MAIDEN NAME <b>DOROTHY CRABTREE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>A 645266</b>		17. INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>154X Metastatic Carcinoma of Prostate</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1yr</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension, Atherosclerosis, Coronary Artery Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1959</b> to <b>Aug 1960</b> that (I) (we) last saw the deceased alive on <b>Aug 10 1960</b> and that death occurred at <b>11:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Overton Himmelwright</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/13/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. OVERTON HIMMELWRIGHT</b>				22d. ADDRESS <b>13309 Ave Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 13, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 15 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Carl S. Kline</b>			

08334

CERTIFICATE OF DEATH

8610

(M)



STANDARD

DEPARTMENT

HEALTH

CERTIFICATE

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08625

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW CREEK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK &amp; MEMORIAL MEMORIAL HOSPITAL AVES.</b>		d. STREET ADDRESS <b>85X-3</b>	
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL</b> Last <b>EVANS</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 12, 1960</b>
9. AGE (In years lost birthday) yrs. <b>15</b>		10. IF UNDER 1 YEAR Months Days <b>15</b> IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JAMES A. EVANS</b>		14. MOTHER'S MAIDEN NAME <b>DONNA L. MOORE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>774X Enoxia</b> DUE TO (b) <b>Dr. Maternity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>4:20 A.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. S. Hodges &amp; Mould</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. S. HODGES &amp; MOULD</b>		22d. ADDRESS <b>122 SOUTH CENTRE STREET</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>8-4-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Hospital Cumberland, Maryland</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Memorial Hospital Cumberland, Md</b>		25a. REC'D BY REGISTRAR <b>EUG 8 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

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CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8642

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08626

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Mt. Savage</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>1 Decatur St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William E. Farrell</b> First Middle Last				4. DATE OF DEATH Month <b>8</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-20-84</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mine &amp; Mill Supply Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John Farrell</b>				14. MOTHER'S MAIDEN NAME <b>Anna Gaughan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-05-6714</b>		17. INFORMANT <b>Patient's chart</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.8 AZOTEMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>CARCINOMA OF COLON WITH HEPATIC METASTASIS 1-2 YRS.</b> DUE TO (c) <b>VESICO-SIGMOIDAL FISTULA</b> 3 MONTHS				INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 17, 1960</b> to <b>AUG. 15, 1960</b> , that (II) (we) last saw the deceased alive on <b>8-14 1960</b> , and that death occurred at <b>6 P.</b> M., from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard E. Schindler</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Richard E. Schindler, M.D.</b>				22d. ADDRESS <b>69 GREENE ST. - CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-18-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.R. Durst</b>				ADDRESS <b>Frostburg, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 18 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

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CERTIFICATE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8681

08627

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Lonaconing</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>FISHER</b> Last <b>FISHER</b>				4. DATE OF DEATH Month <b>8</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/20/1872</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min.	IF UNDER 24 HRS. Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE FOOT</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH BUCKEL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. MARSHALL CREIGHTON, Lonaconing, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral hemorrhage</b> DUE TO <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(DAUGHTER)</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>14 days</b> <b>years</b>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <b>July 29, 1960 to Aug 18, 1960</b> 21. I certify that (I) (this hospital) attended the deceased from <b>July 29, 1960</b> to <b>Aug 18, 1960</b> , that (I) <del>was</del> lost saw the deceased alive on <b>Aug 18, 1960</b> , and that death occurred at <b>5 AM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Dr. Miles</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b> 22d. ADDRESS <b>Lonaconing, MD.</b> 22b. DATE SIGNED <b>8.20.60</b>							
23a. BURIAL, CREMATION, REMOVAL (specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/21/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>				ADDRESS <b>Lonaconing, MD.</b>		25a. RECEIVED BY REGISTRAR <b>AUG 23 60</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8682 CERTIFICATE OF DEATH 08628

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Beachwood Street</b>				d. STREET ADDRESS <b>Beachwood Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elias</b> Middle <b>Frye</b> Last <b>Frye</b>				4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 15, 1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>	
13. FATHER'S NAME <b>David Frye</b>				14. MOTHER'S MAIDEN NAME <b>Isabelle Naismith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-07-2717</b>		17. INFORMANT <b>Havey Frye</b> Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Centeniosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Diabetes Mellitus</b> DUE TO <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b> <b>years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 12, 1957</b> to <b>Aug 12, 1960</b> , that (I) (we) last saw the deceased alive on <b>Aug 11, 1960</b> , and that death occurred at <b>8</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Samuel J. Miles, M.D.</b>				22b. DATE SIGNED <b>8-18-60</b>		22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>	
22d. ADDRESS <b>LONA CONING MD.</b>				22e. ADDRESS <b>LONA CONING MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/19/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	
23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>				23e. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 22 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>				25c. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08629

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>51 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>			d. STREET ADDRESS <b>135 INDEPENDENCE STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LUCY</b> Middle <b>M.</b> Last <b>GILPIN</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>14</b> , Year <b>1960</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 5, 1906</b>		9. AGE (In years last birthday) yrs. <b>54</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>KEYSER, W. VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>DORA TAYLOR</b>			14. MOTHER'S MAIDEN NAME <b>ETTA HERBAUGH</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220 28 9561</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Lung.</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Breast</b> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6-12 1960 to 8-14 1960</b>	
20f. (City or town) <b>Keyser, W. Va.</b>		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-12 1960</b> to <b>8-14 1960</b> , that (I) (we) last saw the deceased alive on <b>8-14 1960</b> and that death occurred at <b>9:07 AM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>William P. James</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM P. JAMES</b>		22d. ADDRESS <b>441 N. CENTRE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 17, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Queens Point Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Keyser, W. Va.</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 17 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>					

08643

NEW YORK STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

88-12

(M)

ALLEGANY

MARRIED

ALLEGANY

CORNER

21 DAYS

CORNER

WILLIAM A. HENRIKSON  
NEW YORK HOSPITAL

132 INDEPENDENCE STREET

LUCKY

GILPIN

AUGUST 11, 1900

MARCH 2, 1900

WHITE

FEMALE

JOSEPH W. VA.

JOHN TAYLOR

ETNA HOSPITAL

NEW YORK HOSPITAL - CORNER

*Handwritten signature and text:*  
J. W. VA.  
J. W. VA.

DR. WILLIAM R. LINDS

101 N. FRONT ST., CORNER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08630

Reg. Dist. No.

8644

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CUMBERLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>CASH VALLEY ROAD RT. # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard J. Grahame</u>				4. DATE OF DEATH Month Day Year <u>8- 18 19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 22 1898</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor-Liberty Trust</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Liberty Trust Co.</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland, Mt. Savage</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Jonas Grahame</u>				14. MOTHER'S MAIDEN NAME <u>Hergott, Alice G/</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-2496</u>		17. INFORMANT Wife: <u>Susie Grahame</u>		Address <u>Same Address.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. B. Skitarelic MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>August 18, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 20, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Restlawn Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Allegany County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>				ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>Aug 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles A. Knoch</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8814

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1910		NEW YORK	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED	
123 MAIN ST. BOSTON		Carpenter		High School		Married		1935		1935	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
1940		Home		Heart Disease		Natural		Coronary Artery Disease		Chest Pain, Shortness of Breath	
TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		CONSCIOUSNESS	
10:00 AM		98.6		60		120/80		16		Alert	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		OFFICE OF EXAMINER		STATE OF MASSACHUSETTS		COUNTY OF SUFFOLK	
[Signature]		1940		BOSTON		[Signature]		[Signature]		[Signature]	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08631

8645

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>25 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MILDRED</b> Middle <b>VIVIAN</b> Last <b>GRAPES</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>28</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 4, 1931</b>	
9. AGE (In years last birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HWFE. &amp; REG. NURSE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>OTTO K. RYAN</b>				14. MOTHER'S MAIDEN NAME <b>NELLIE N. HOWSARE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-26-9999</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia (acute myeloid) 204.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>92-94 + retroperitoneal</b> DUE TO (c) <b>28 hrs (marble fetus)</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pregnancy</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1960</b> to <b>28 Aug. 1960</b> that (I) (we) last saw the deceased alive on <b>28 Aug. 1960</b> and that death occurred at <b>2:00 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>F. B. Whitworth</b> M.D.				22b. DATE SIGNED <b>29 Aug 60</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. F. B. WHITWORTH</b>	
22d. ADDRESS <b>Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/30/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				ADDRESS <b>Cumberland Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 31 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			

100000

CERTIFICATE OF DEATH

2017

(M)

ALLIANCE

MARYLAND

ALLIANCE

CORRESPONDENCE

82 DAYS

CORRESPONDENCE

ROUTE 11

WOMAN'S HOSPITAL

100000

GRAVES

VILLAGE

WOMAN'S

MARCH 1, 1931

WOMAN'S

U.S.A.

CORRESPONDENCE, MARYLAND

WOMAN'S

WOMAN'S

WOMAN'S

(1)

WOMAN'S HOSPITAL - CORRESPONDENCE, MARYLAND

DR. J. H. WHITMAN

WOMAN'S HOSPITAL - CORRESPONDENCE, MARYLAND

WOMAN'S HOSPITAL - CORRESPONDENCE, MARYLAND



8684

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08632  
08-32

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>101 HAMMOND</b>		d. STREET ADDRESS <b>101 HAMMOND</b>		
3. NAME OF DECEASED (Type or print) First <b>ALLAN</b> Middle <b>MAIR</b> Last <b>GRIFFITH</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>14</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 11, 1893</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Company</b>		
11. BIRTHPLACE (State or foreign country) <b>Eckart, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William B. Griffith</b>		14. MOTHER'S MAIDEN NAME <b>Annie Mair</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>23603-2574</b>		
17. INFORMANT <b>Mrs. Richard Whitworth, Westernport, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Rectum</b> DUE TO <b>154X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1960</b> to <b>Aug 14, 1960</b> that (I) (we) last saw the deceased alive on <b>Aug 14, 1960</b> , and that death occurred at <b>Aug 14, 1960</b> M, from the causes and on the date stated above.				
22a. SIGNATURE <b>James A. Whitworth Jr.</b>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Aug. 16, '60</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Westernport, Maryland</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. L. Boal</b>		25a. REC'D BY REGISTRAR <b>Aug 18 '60</b>		
ADDRESS <b>Westernport, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		

8084

(N)

(1)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8646  
CERTIFICATE OF DEATH

08633

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>8 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LONA CONING</b>	
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle Last <b>GROVE</b>		4. DATE OF DEATH Month <b>AUGUST 16,</b> Day Year <b>19 60.</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 21, 1896</b>
9. AGE (In years last birthday) yrs. <b>64</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>IF UNDER 24 HRS.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM GARDNER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH J. WILSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardio</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>vascular renal disease?</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>8-7-60</b> to <b>8-16-60</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>8-15-60</b> and that death occurred at <b>1:00 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. J. Williams</b> M.D.		22b. DATE SIGNED <b>8-17-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS.</b>		22d. ADDRESS <b>122 SO. CENTRE STREET, CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/18/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 22 '60</b>	
ADDRESS <b>LONA CONING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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8848

ALLEGANY

WARRIANT

ALLEGANY

ALLEGANY

5 DAYS

WARRIANT

25 WASHINGTON STREET

WARRIANT & MEDICAL AGENCY

AUGUST 11

GROVE

ETHEL

DANIEL J. BROWN

ETHEL

U.S.A.

WARRIANT

WARRIANT

GROVE J. WARRIANT

WARRIANT

WARRIANT & MEDICAL AGENCY

WARRIANT

125 25 WASHINGTON STREET, WARRIANT, MD.

WARRIANT

WARRIANT

WARRIANT

WARRIANT

WARRIANT

WARRIANT

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8686 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08634

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cumberland</b>		c. LENGTH OF STAY IN 1b <b>X Rural- Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D. 2 Box 755</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Mylerd</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1894 March 20, 1960</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min. <b>6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locomotive Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Whitemarsh, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hall</b>		14. MOTHER'S MAIDEN NAME <b>Georgeanna Mayhew</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-108467</b>	
17. INFORMANT <b>Mrs. Marcella Hall</b>		Address <b>R.F.D. 2 Box 755</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>****</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 29, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08034

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8034

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER		13. DATE		14. TIME		15. LOCATION		16. COMMENTS	
JOHN J. HALL		Male		45		White		Carpenter		Baltimore, Md.		Jan 15, 1920		Jan 15, 1920		Baltimore, Md.		Heart Disease		Natural		J. J. Hall		Jan 15, 1920		10:00 AM		1000 North Street		No other diseases noted.	
17. SIGNATURE OF WITNESS		18. DATE		19. TIME		20. LOCATION		21. COMMENTS		22. SIGNATURE OF EXAMINER		23. DATE		24. TIME		25. LOCATION		26. COMMENTS		27. SIGNATURE OF EXAMINER		28. DATE		29. TIME		30. LOCATION		31. COMMENTS		32. SIGNATURE OF EXAMINER	
J. J. Hall		Jan 15, 1920		10:00 AM		1000 North Street		No other diseases noted.		J. J. Hall		Jan 15, 1920		10:00 AM		1000 North Street		No other diseases noted.		J. J. Hall		Jan 15, 1920		10:00 AM		1000 North Street		No other diseases noted.		J. J. Hall	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** **08635**  
**8687 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u> c. LENGTH OF STAY IN lb <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2, Frostburg</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 2, Frostburg</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Marshall</u> Middle <u>N.</u> Last <u>Harvey</u>				<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>8th</u> Year <u>1960</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 27th 1912</u>		<b>9. AGE</b> (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Carpenter</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>West Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Amos D. Harvey</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary A. Fike</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>WW 2 218-09-5383</u>		<b>17. INFORMANT</b> <u>Mrs. Norma M. Harvey, Rt. 2, Frostburg, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS WITH THROMBOSIS</u> DUE TO (c) <u>---</u>								INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Scaloties</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>W O M C Lane</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>Aug 8 1960</u>	
<b>EXAMINER'S NAME (Type)</b> <u>W. O. McLane,</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>8-10-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Fairview Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Garrett County, Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J R Rount</u>				<b>ADDRESS</b> <u>Frostburg</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE AUG 11 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND—DEPARTMENT OF HEALTH—BALTIMORE, 12

10

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8647

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08636

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>60yrs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>905 Louisiana Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Mary Ann Haselberger</b> First Middle Last				4. DATE OF DEATH Month <b>Aug.</b> Day <b>3,</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1875</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ownhome</b>		11. BIRTHPLACE (State or foreign country) <b>Wisha, Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter McKenna</b>				14. MOTHER'S MAIDEN NAME <b>Susan Healey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. J. Edwin Keech 905 Louisiana Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC MYOCARDITIS</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>----</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACTURE OF LEFT FEMUR</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL AT HOME TRYING TO GET IN BED</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>10:00 July 7 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cumberland, Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>AUGUST 3, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-6-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE AUG 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial or removal.

0530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After a certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

8685

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08637

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY,</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTERNPORT</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>430 VINE STREET</b>		d. STREET ADDRESS <b>430 VINE STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>MILLESON</b> Last <b>HINES</b>		4. DATE OF DEATH Month <b>8</b> / Day <b>14</b> / Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1892</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own shop</b>	
11. BIRTHPLACE (State or foreign country) <b>Romney, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Hines</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Shank</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Donald Hines, 428 Vine St., Westernport, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>027X Congestive heart failure</b> DUE TO (b) <b>Tertiary Luetic Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>26 yrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1959</b> to <b>Aug 14 1960</b> , that (I) (we) last saw the deceased alive on <b>Aug 13th</b> 19 <b>1960</b> , and that death occurred at <b>4:50</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>William W. Lish</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Aug. 17, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ed Bral</b>		ADDRESS <b>Westernport, Maryland</b>	
25a. REC'D BY REGISTRAR <b>AUG 18 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton L. Hines</b>	

48837

CERTIFICATE OF DEATH

48837

1

*Robert L. ...*  
*...*

*Robert L. ...*

*...*



VS. A15ME(5)  
5M 9/55

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8688

08638

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Cumberland</b>		c. LENGTH OF STAY IN lb <b>31 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Park</b>		d. STREET ADDRESS <b>Potomac Park</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES FRANKLIN JEFFERYS</b>		4. DATE OF DEATH Month <b>August</b>		Day <b>8</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 28, 1877</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Richard Jefferys</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215 16 4304</b>		17. INFORMANT <b>Roy E. Jefferys</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC</b>		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		August 10, 1960		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 12, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Maplewood Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Kingwood, W. Va.</b>		(State)		23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>		Cumberland, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8674

08639

1. PLACE OF DEATH a. COUNTY: <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Lonaconing</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				d. STREET ADDRESS <b>Island Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles G. Jeffries</b>				4. DATE OF DEATH Month Day Year <b>August 30 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 17, 1880</b>	
9. AGE (In years lost birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (State or foreign country) <b>Frostburg, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John M. Jeffries</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Tobey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Russell Jeffries</b> Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>"Nephew"</b> <b>Cerebral Vascular Accident</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease.</b> DUE TO (c) <b>10 yr.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3.5 hr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1:00 P.M. 9/30, 1960</b> , to <b>3:30 P.M. 9/30, 1960</b> , that (I) ( <del>was</del> ) lost saw the deceased alive on <b>9/30</b> 1960, and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Alvin J. Warters</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Alvin J. Warters M.D.</b>				22d. ADDRESS <b>48 Broadway, Frostburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/2/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 6 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8648

CERTIFICATE OF DEATH

08640

Item 9 Film 271 9-14-60 st

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>21 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>512 HILL ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>JONES</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>8-28-60</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-1877</b>
9. AGE (In years lost birthday) <b>82</b> rs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic worker</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN JONES</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220 07 6722</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> (c) <b>3 weeks</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma Right Upper Lobe; CNS Syphilis (Ritony)</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7 Aug 1960</b> to <b>28 Aug 1960</b> ; that (I) (we) lost saw the deceased alive on <b>27 Aug 1960</b> , and that death occurred at <b>8:50 A. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Almeida</b>		22b. DATE SIGNED <b>8/28/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>		22d. ADDRESS <b>57 Greenest Cumberland, Md, 187</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 31, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sumner Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 1 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			

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CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8649

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 12, Film G269 8/16/60 1b

Reg. Dist. No.

08641

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Levin</b> Last				4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 15 1886</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Joseph Levin Cumberland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2-3 Hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an <del>autopsy</del> inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>August 9, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 10, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Eastview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Stevenson</b>				ADDRESS <b>117 Frederick St. Cumb. Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 12 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial or removal. File pages 1 and 2 with the registrar prior to burial or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8650

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08642

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>223 Harrison Street</u>			d. STREET ADDRESS <u>223 Harrison Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>ROSS</u> Last <u>LUAN</u>			4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1884</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Dry Ridge, Pennsylvania</u>	
13. FATHER'S NAME <u>Barton Luman</u>			14. MOTHER'S MAIDEN NAME <u>Christina Shaffer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-03-9959</u>		17. INFORMANT <u>Mrs. Bruce Luman</u> Address <u>Cumberland, Md.</u> <u>223 Harrison Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Third degree burns of chest and neck</u> (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned Self While Lighting Pipe</u>			
20c. TIME OF INJURY Month, Day, Year <u>5:00 a.m.</u> <u>May 23 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>Home</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>223 Harrison St., Cumberland Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>August 7, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 8/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>	
22d. LOCATION (City, town, or county) <u>Cumberland Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>			
24a. REC'D BY REGISTRAR DATE <u>AUG 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8651

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08643

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN lb <u>17</u> days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		d. STREET ADDRESS <u>27 N. LIBERTY STREET</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LOLETA</u> Middle <u>BELL</u> Last <u>MC CORMICK</u>		4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>19 60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/94</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IOWA</u>	
11. BIRTHPLACE (State or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HOUT</u> (D.)		14. MOTHER'S MAIDEN NAME <u>CELESTE CENTERS</u> (D)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>William McCormick</u>	
17. INFORMANT <u>(SON)</u>		Address <u>Cumberland, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism, massive</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Retroperitoneal pelvic hematoma, diffuse</u> DUE TO (c) <u>2 weeks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>578X</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Benedict Skitarellic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>AUGUST 16, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/19/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lonaconing, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE EICHHORN</u>		ADDRESS <u>LONA CONING, MD.</u>	
24a. REC'D BY REGISTRAR <u>AUG 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>	



1388



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

1  
#  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8652 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08644

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>48 Marion Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>R.</b> Last <b>MCDONALD</b>				4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 15, 1904</b>	
9. AGE (in years last birthday) <b>56</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Filtration Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>Eckhart, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William McDonald</b>				14. MOTHER'S MAIDEN NAME <b>Annie Browning</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>217-10-4285</b>		17. INFORMANT <b>Mrs. Dorothy McDonald</b> Address <b>48 Marion Street, Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>-----</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelis</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>August 3, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 6, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hafer</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

8653

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08645

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>McMULLIN</u> Last <u></u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>13,</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13, 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Lape</u>		14. MOTHER'S MAIDEN NAME <u>Mary Claycomb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Memorial Hospital Records, Cumberland, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic nephritis and pyelonephritis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 16, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Allegany County Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u></u>	



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(M)

8654

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08646

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL</b> Last <b>METZ</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>19</b> Year <b>19 60</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 15, 1960</b>	
9. AGE (In years last birthday) <b>4</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b>4</b> Min.		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>KEYSER, W.VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>RAYMOND E. METZ</b>				14. MOTHER'S MAIDEN NAME <b>REBA JEAN ARTHUR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature death 24 8<sup>00</sup></b> DUE TO <b>One of 9 yrs -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac failure.</b> DUE TO (c) <b>1 day</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>8:17 - 60</b> <b>19 60</b> <b>8:35 A.M.</b> , that (I) (we) last saw the deceased alive on <b>8/16</b> <b>19 60</b> , and that death occurred at <b>2:35</b> <b>M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>H.W. Eliason</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. H.W. ELIASON</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>8/20/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Law Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Moscow Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>El. Boral - Westernport, Md</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

MEDICAL CERTIFICATION

1

Nov. 1960



08880

CERTIFICATE OF DEATH

8888



MINERAL

WEST VIRGINIA

ALLEGANY

DECEASED

DATE

NUMBER

124 WEST 10 STREET

MEMORIAL HOSPITAL

AUGUST 10

DECEASED

GIRL

BABY

AUGUST 10, 1920

WHITE

U.S.A.

DECEASED

NOTE

DECEASED

DECEASED

MEMORIAL HOSPITAL - CLEVELAND, OHIO





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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8655  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08647

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived., If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>66 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LUCY</b> Middle <b>M.</b> Last <b>MONNETT</b>		4. DATE OF DEATH Month <b>8</b> Day <b>-2-</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-8-1894</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NICHOLAS WEBER</b>		14. MOTHER'S MAIDEN NAME <b>LUCY HUFF</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-03-9401</b>	
17. INFORMANT <b>PTS. CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>744.0</b> IMMEDIATE CAUSE (a) <b>Myasthenia Gravis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March</b> 19 <b>60</b> to <b>Aug. 2</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Aug. 2</b> 19 <b>60</b> , and that death occurred at <b>3:15 P.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Geo. N. Ley Jr.</b>		22b. DATE SIGNED <b>8/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. L. H. LEY.</b>		22d. ADDRESS <b>456 N. Centre St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-5-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 8 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

08045

8823

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

8675

08648

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN lb <b>1 hr</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>F.</b> Last <b>Mullin</b>				4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 23, 1890</b>	
9. AGE (In years last birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Franklin R. Mullin</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Stewart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>376-03-2777</b>			
17. INFORMANT <b>"Sister"</b>				Address <b>Miss. Margaret Mullin Lonaconing, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>523.0</b> DUE TO <b>Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary insufficiency</b> DUE TO (c) <b>Pneumonia - bilious</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Complete heart block</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>August 1, 1960</b> to <b>Aug 1, 1960</b> , that (I) (we) lost saw the deceased alive on <b>Aug 1, 1960</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>William W. Lesh M.D.</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>William W. Lesh M.D.</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/4/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 5 '60</b>			
ADDRESS <b>Lonaconing, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

Bp

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8676

08649

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MINERS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>LUDIA</b> Last <b>NATOLLY</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>28</b> , Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-9-1891</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL T. LOWERY</b>		14. MOTHER'S MAIDEN NAME <b>ALCINDA YOST</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>CARL NATOLLY, MT. SAVAGE, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>155.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the Gall Bladder</b> DUE TO (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>July 15, 1960</b> , to <b>Aug 28, 1960</b> , that (I) (we) last saw the deceased alive on <b>Aug 28, 1960</b> , and that death occurred at <b>2400</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Alvin J. Walters</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>ALVIN J. WALTERS, M. D.</b>		22d. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-31-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>METHODIST CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>MT. SAVAGE, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Burst</b>		25a. REC'D BY REGISTRAR <b>SEP 1 '60</b>	
ADDRESS <b>FROSTBURG, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Cecilia S. Kraus</b>	



061

MEDICAL CERTIFICATION

04380

2528

101-9-1

0116-2744



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: At this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08650

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>504 RIDGEWOOD AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>NEAT</b> Last		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 1, 1886</b>
9. AGE (In years lost birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad B. &amp; O. R.R.CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND Barton</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL NEAT, SR.</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET REES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-05-4752</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peripheral vascular collapse</b> DUE TO <b>578X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>unmedicated peritonitis</b> DUE TO <b>Perforated small intestine</b> (c) <b>Right heart failure - Pulmonary fibrosis - Obesity</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>48 hrs</b> <b>60 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right heart failure - Pulmonary fibrosis - Obesity</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 24</b> 19 <b>60</b> to <b>Aug 27</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Aug 27</b> 19 <b>60</b> , and that death occurred at <b>12:10 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas F. Lewis</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. THOMAS LEWIS</b>		22d. ADDRESS <b>Algonquin Hotel Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-31-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg, Maryland</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		25a. REC'D BY REGISTRAR <b>SEP 1 '60</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

1938

ALLIANCE

CONSTITUTION, PENNSYLVANIA

2 DAYS

CONSTITUTION

GENERAL HOSPITAL

FOR RICHMOND AVENUE

CARTEL

HEAT

WICKET

WHITE

DECEMBER 1, 1938

RETIRED HOUSEWIFE

D. A. C. R. B. 1901

IMMEDIATE REPLY

CARTEL HEAT, C.

GENERAL HOSPITAL - CONSTITUTION, PENNSYLVANIA

DR. JAMES LEWIS

12:10 P.M.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, and Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, and Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, and Page 3 should be used as a burial-transit permit.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8657

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08651

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>14yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Brooks Hotel 202 Baltimore Ave</b>				d. STREET ADDRESS <b>Brooks Hotel 202 Baltimore Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Raymond F. Neel</b>				4. DATE OF DEATH Month Day Year <b>August 20 1960</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 26, 1900</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Soldier</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S Marine</b>		11. BIRTHPLACE (State or foreign country) <b>Palestine, Texas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Jesse Neel</b>				14. MOTHER'S MAIDEN NAME <b>Jessie Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>War II</b>				16. SOCIAL SECURITY NO. <b>220-28-7646</b>		17. INFORMANT Address <b>Mrs. R.W. Helmick 4385 E. I42nd St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>Cleveland, Ohio</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Aug. 20, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-23-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Cem.</b>		22d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 23 '60</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08221

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
MARITAL STATUS [Faint text]		CAUSE OF DEATH [Faint text]	
MEDICAL HISTORY [Faint text]		PRESENT ILLNESS [Faint text]	
PHYSICIAN'S SIGNATURE [Faint text]		MEDICAL EXAMINER'S SIGNATURE [Faint text]	
DATE OF EXAMINATION [Faint text]		TIME OF EXAMINATION [Faint text]	
PLACE OF EXAMINATION [Faint text]		CITY AND COUNTY [Faint text]	
STATE [Faint text]		ZIP CODE [Faint text]	
SIGNATURE OF MEDICAL EXAMINER [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
DATE OF SIGNATURE [Faint text]		TIME OF SIGNATURE [Faint text]	
PLACE OF SIGNATURE [Faint text]		CITY AND COUNTY [Faint text]	
STATE [Faint text]		ZIP CODE [Faint text]	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8658

08652

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>20 DAYS</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>22 ARCH STREET</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>ADDIE</b> Middle <b>B.</b> Last <b>NORTON</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>22</b> Year <b>1960</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOVEMBER 11, 1876</b>			
9. AGE (In years lost birthday) yrs. <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <b>PAW PAW, W. VIRGINIA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>JAMES GRANT</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH DEVER</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.					
17. INFORMANT <b>WARWICK &amp; MEMORIAL AVENUES MEMORIAL HOSPITAL P CUMBERLAND, MD.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X Hemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Stomach &amp;</b> DUE TO <b>carcinomatosis</b> (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that death occurred on <b>12:01 AM</b> the causes and on the date stated above.									
22a. SIGNATURE <b>DR. EARL R. PAUL</b>				22b. DATE SIGNED <b>AUG 25 '60</b>					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>36 GREENE STREET, CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Aug. 24, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>			
23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>									
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 25 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>William L. ...</b>									

8858

CERTIFICATE OF DEATH

08858

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CHAMBERLAIN

MEMORIAL HOSPITAL

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DOUGLAS

PAW PAW, W. VIRGINIA

U.S.A.

JAMES CHART

ELIZABETH DEVER

MEMORIAL HOSPITAL & CHAMBERLAIN, MD.

DR. EARL P. PAUL

20 DEWEY STREET, CHAMBERLAIN, MD.

CHAMBERLAIN, MARYLAND

CHAMBERLAIN, MARYLAND

CHAMBERLAIN, MARYLAND





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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8660

08654

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>VERNA</b> Middle <b>C.</b> Last <b>PORTER</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>10</b> Year <b>19 60</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 14, 1898</b>	
9. AGE (In years lost birthday) yrs. <b>62</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOE SPIKER</b>				14. MOTHER'S MAIDEN NAME <b>ALICE MOORE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>MEMORIAL &amp; WARBUCK AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Hypertensive and arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>5 years</b> <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hepato-renal fibrosis 14 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>20 Dec. 1959</b> to <b>10 Aug. 1960</b> that (I) (we) last saw the deceased alive on <b>9 Aug. 1960</b> and that death occurred at <b>1:40 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. Alfred Van Ormer</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>				22d. ADDRESS <b>122 SOUTH CENTRE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-12-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Duost</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 15 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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ALICE MOORE  
1000 1st & AMERICAN AVENUE  
ALLEGANY COUNTY - ALLEGANY, ALLEGANY

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CHITLAND

## CERTIFICATE OF DEATH

Reg. Dist. No.

08655

8661

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>116 Valley St.</u>		d. STREET ADDRESS <u>116 Valley St.</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Catherine Powers</u>		4. DATE OF DEATH <u>Aug 28, 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1859</u>
9. AGE (In years last birthday) <u>101</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Langer</u>		14. MOTHER'S MAIDEN NAME <u>Christine Stough</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John E. Powers, Cumb. Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>450.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/26</u> , 19 <u>60</u> , to <u>8/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/26</u> , 19 <u>60</u> , and that death occurred at <u>10:15 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leo H. Ley Jr.</u>		ADDRESS (Street, city or town, state) <u>450 N. Centre</u>	
PHYSICIAN'S NAME (Type) <u>LEO H. LEY JR.</u>		DATE SIGNED <u>8/29/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/31/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md.</u>	
24a. REG'D BY REGISTRAR <u>AUG 31 1960</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hanks</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

88825

88825

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>10/15/1910</i>		5. PLACE OF BIRTH <i>NEW YORK</i>	
6. OCCUPATION <i>CLERK</i>		7. MARITAL STATUS <i>MARRIED</i>		8. DATE OF MARRIAGE <i>05/10/1935</i>		9. PLACE OF MARRIAGE <i>NEW YORK</i>		10. NAME OF SPOUSE <i>MARY J. SMITH</i>	
11. CAUSE OF DEATH <i>HEART DISEASE</i>		12. MANNER OF DEATH <i>NATURAL</i>		13. PLACE OF DEATH <i>HOSPITAL</i>		14. DATE OF DEATH <i>01/10/1955</i>		15. TIME OF DEATH <i>10:00 AM</i>	
16. SIGNATURE OF PHYSICIAN <i>J. H. SMITH</i>		17. SIGNATURE OF REGISTRAR <i>M. J. SMITH</i>		18. SIGNATURE OF WITNESS <i>J. H. SMITH</i>		19. SIGNATURE OF WITNESS <i>M. J. SMITH</i>		20. SIGNATURE OF WITNESS <i>J. H. SMITH</i>	

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THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

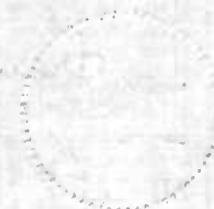
8677

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08656

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 FROSTBURG</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>128 W. COLLEGE AVENUE</b>		d. STREET ADDRESS <b>128 W. COLLEGE AVENUE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>(SCHRAMM)</b> Last <b>PRESSMAN</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 7, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>5</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>GEORGE SCHRAMM</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>EARL PRESSMAN, FROSTBURG, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxic myocarditis</b> <b>605X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Uremia</b> (c) <b>Chronic hepatitis + Pyelonephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>50 hrs.</b> <b>7 days</b> <b>7 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis especially cerebral.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/23, 1959</b> to <b>8/13, 1960</b> that <b>he</b> lost saw the deceased alive on <b>6/10, 1960</b> , and that death occurred at <b>4:40</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank T. Harrat</b>		22b. DATE SIGNED <b>9/1/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. T. HARRAT, M. D.</b>		22d. ADDRESS <b>26 W. MECHANIC ST., FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-2-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK</b>		23d. LOCATION (City, town, or county) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. P. Durr</b>		25a. REC'D BY REGISTRAR <b>SEP 2 '60</b>	
ADDRESS <b>FROSTBURG, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>C. J. S. Kline</b>	

508



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOSEPH ROBERTSON</b>				4. DATE OF DEATH <b>8/10/1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 24th. 1884</b>	
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kelly Tire Plant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Ocean, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph Robertson</b>				14. MOTHER'S MAIDEN NAME <b>Drucilla Foote</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>220-10-20534</b>		17. INFORMANT <b>Mr. Gorman Robertson, Midland, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage (SON)</b> 321X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) <b>6 hours</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>Aug 10, 1960</b> that (I) (we) last saw the deceased alive on <b>Aug 10, 1960</b> , and that death occurred at <b>4 p.m.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Drucilla Foote</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8-11-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>				22d. ADDRESS <b>LONACONING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/13/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>				ADDRESS <b>LONACONING, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>AUG 15 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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(M)

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "REPORT", "DATE", and "BY" are faintly visible.]*

*[Faint text at the bottom of the page, including what appears to be a signature and a date.]*

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8662  
CERTIFICATE OF DEATH

08658

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>55 MINUTES</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>		e. STREET ADDRESS <b>522 A STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>ROSENMERKEL</b> Middle <b>ROSENMERKEL</b> Last <b>ROSENMERKEL</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 10, 1960</b>
9. AGE (In years lost birthday) yrs. <b>55</b>		IF UNDER 1 YEAR Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min. <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>CUMBERLAND, MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM P. ROSENMERKEL</b>		14. MOTHER'S MAIDEN NAME <b>NANCY L. RANDALL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>761.05 Prematurely (Hemorrhage)</b> DUE TO <b>Premature Separation Placental</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Premature Separation Placental</b> DUE TO <b>Premature Separation Placental</b> (c) <b>Premature Separation Placental</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred <b>12:45 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>F. B. WHITWORTH</b>		22b. DATE SIGNED <b>12:45 AM</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. B. WHITWORTH</b>		22d. ADDRESS <b>123 BEDFORD ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>8-11-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL HOSPITAL</b>		23d. LOCATION (City, town, or county) (State) <b>CUMBERLAND, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Memorial Hospital - Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 15 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		25c. REGISTRAR'S SIGNATURE	

2160 343XV 0

2589

5022



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8663 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08659

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY in 1b <u>20 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Retreat</u>				d. STREET ADDRESS <u>Queen City Pavement</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARK</u> <u>W.</u> <u>SCHULTZ</u>				4. DATE OF DEATH Month Day Year <u>August</u> <u>11</u> <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>			
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Schultz</u>				14. MOTHER'S MAIDEN NAME <u>Sara Schultz</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Russell Schultz, Strongstown, Pa.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS AND THROMBOSIS</u> DUE TO (c) <u>-----</u>								INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>August 11, 1960</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>A legany County Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 15 '60</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

03559

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

88032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED: <u>JOHN J. SMITH</u></p>		<p>2. SEX: <u>Male</u></p>	
<p>3. AGE: <u>45</u></p>		<p>4. RACE: <u>White</u></p>	
<p>5. DATE OF BIRTH: <u>1910</u></p>		<p>6. PLACE OF BIRTH: <u>St. Louis, Mo.</u></p>	
<p>7. OCCUPATION: <u>Engineer</u></p>		<p>8. RESIDENCE: <u>1234 Main St., Baltimore, Md.</u></p>	
<p>9. DATE OF DEATH: <u>1955</u></p>		<p>10. TIME OF DEATH: <u>10:00 AM</u></p>	
<p>11. CAUSE OF DEATH: <u>Myocardial Infarction</u></p>		<p>12. MANNER OF DEATH: <u>Natural</u></p>	
<p>13. SIGNATURE OF EXAMINER: <u>[Signature]</u></p>		<p>14. PRINTED NAME OF EXAMINER: <u>Dr. J. H. Jones</u></p>	
<p>15. SIGNATURE OF WITNESS: <u>[Signature]</u></p>		<p>16. PRINTED NAME OF WITNESS: <u>John Doe</u></p>	
<p>17. SIGNATURE OF CORONER: <u>[Signature]</u></p>		<p>18. PRINTED NAME OF CORONER: <u>John Doe</u></p>	
<p>19. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>20. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>21. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>22. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>23. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>24. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>25. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>26. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>27. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>28. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>29. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>30. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>31. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>32. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>33. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>34. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>35. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>36. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>37. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>38. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>39. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>40. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>41. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>42. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>43. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>44. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>45. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>46. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>47. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>48. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>49. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>50. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>51. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>52. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>53. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>54. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>55. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>56. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>57. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>58. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>59. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>60. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>61. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>62. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>63. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>64. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>65. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>66. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>67. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>68. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>69. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>70. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>71. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>72. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>73. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>74. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>75. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>76. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>77. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>78. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>79. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>80. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>81. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>82. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>83. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>84. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>85. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>86. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>87. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>88. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>89. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>90. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>91. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>92. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>93. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>94. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>95. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>96. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>97. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>98. PRINTED NAME OF JURY: <u>John Doe</u></p>	
<p>99. SIGNATURE OF JURY: <u>[Signature]</u></p>		<p>100. PRINTED NAME OF JURY: <u>John Doe</u></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
8664  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08660

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>6/11/60</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hoffman</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmiry</b>				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Andrew</b> Middle <b>Seifarth</b> Last <b>Seifarth</b>				4. DATE OF DEATH Month <b>August</b> Day <b>8,</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/3/1882</b>	
9. AGE (In years lost birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. AGE (In years lost birthday) <b>78</b> yrs.		12. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired : Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (State or foreign country) <b>Hoffman, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. S.</b>				13. FATHER'S NAME <b>Andrew Seifarth</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Kohl</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>P.O.Box 599</b> <b>Allegany County Infirmiry</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerosis</b> DUE TO <b>Chronic Hepatitis</b> (c) <b>Senile Degeneration</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Degeneration</b>				INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/11/60</b> 19 to <b>8/8/60</b> 19, that (I) (we) last saw the deceased alive on <b>8/6/60</b> 19, and that death occurred at <b>6:15 A.M.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>James E. McLean</b>				22b. DATE <b>8/8/1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>				22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-10-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ECKHART</b>		23d. LOCATION (City, town, or county) (State) <b>ECKHART MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Duxet</b> <b>Frostburg Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 11 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

(M)

091

1



Allegheny

Allegheny

Allegheny

Cumberland

6/11/60

Holtzman

Allegheny County Infirmary

Andrew

Sellars

August

Male

X

2/3/1982

78

Retired : Miner

Mining

Holtzman, Maryland

U. S. S.

Andrew Sellars

Misses Kohl

P. O. Box 297

Cumberland, Md.

Allegheny County Infirmary

ove

6/11/60

6/11/60

6/11/60

Dr. James E. Nolan

22 Argonne Dr., Cumberland, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8689 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08661  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Flintstone</b>		c. LENGTH OF STAY IN 1b <b>8 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 1 Flintstone</b>	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Stevenson</b> Last <b>Shanholtz</b>		4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 29, 1949</b>
9. AGE (In years last birthday) <b>10</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James S. Shanholtz</b>		14. MOTHER'S MAIDEN NAME <b>Cora Morris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>James S. Shanholtz</b>		Address <b>Rt #1 Flintstone, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Transection of cervical spinal cord</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of Neck</b> DUE TO (c) <b>Sudden</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was riding on bicycle when struck by automobile.</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:10 P. m. Aug. 18 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. #40 Near Flintstone Allegany, Maryland</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>August 18, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/21/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glendale Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Flintstone Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Lee Silcox</b>		ADDRESS <b>Cumberland Maryland</b>	
24a. REC'D BY REGISTRAR <b>Aug 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. H... ..</b>	



10880



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8690

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, near Pinto</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Residence, Route 5, Cumberland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>WESLEY</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 4, 1897</b>	
9. AGE (In years last birthday) <b>63 yrs.</b>		IF UNDER 1 YEAR Months <b>63</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Altamont, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>James Smith</b>				14. MOTHER'S MAIDEN NAME <b>Ida M. Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>W W 1</b>		17. INFORMANT <b>Harry E. Smith,</b> Address <b>Penn. Avenue</b> <b>Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>CORONARY SCLEROSIS WITH THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>0</b> p. m. <b>0</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelis</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>AUGUST 24, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 23, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Allegany County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>AUG 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Harris</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

030082

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35 years	
4. RACE White		5. BIRTH DATE 12-1-35		6. BIRTH PLACE Jackson, Mississippi	
7. OCCUPATION None		8. MARITAL STATUS Single		9. EDUCATION High School	
10. PRESENT ADDRESS Room 303, 215 North E Street, Baltimore, Md.		11. DATE OF DEATH 4-4-68		12. TIME OF DEATH 11:00 AM	
13. PLACE OF DEATH Room 303, 215 North E Street, Baltimore, Md.		14. CAUSE OF DEATH Suicide by gunshot		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF EXAMINER J. Edgar Hoover		17. SIGNATURE OF WITNESS J. Edgar Hoover		18. SIGNATURE OF CORONER J. Edgar Hoover	
19. SIGNATURE OF DECEASED JAMES EARL RAY		20. SIGNATURE OF NEXT OF KIN JAMES EARL RAY		21. SIGNATURE OF CLERK J. Edgar Hoover	
22. SIGNATURE OF JURY JAMES EARL RAY		23. SIGNATURE OF JURY JAMES EARL RAY		24. SIGNATURE OF JURY JAMES EARL RAY	
25. SIGNATURE OF JURY JAMES EARL RAY		26. SIGNATURE OF JURY JAMES EARL RAY		27. SIGNATURE OF JURY JAMES EARL RAY	
28. SIGNATURE OF JURY JAMES EARL RAY		29. SIGNATURE OF JURY JAMES EARL RAY		30. SIGNATURE OF JURY JAMES EARL RAY	
31. SIGNATURE OF JURY JAMES EARL RAY		32. SIGNATURE OF JURY JAMES EARL RAY		33. SIGNATURE OF JURY JAMES EARL RAY	
34. SIGNATURE OF JURY JAMES EARL RAY		35. SIGNATURE OF JURY JAMES EARL RAY		36. SIGNATURE OF JURY JAMES EARL RAY	
37. SIGNATURE OF JURY JAMES EARL RAY		38. SIGNATURE OF JURY JAMES EARL RAY		39. SIGNATURE OF JURY JAMES EARL RAY	
40. SIGNATURE OF JURY JAMES EARL RAY		41. SIGNATURE OF JURY JAMES EARL RAY		42. SIGNATURE OF JURY JAMES EARL RAY	
43. SIGNATURE OF JURY JAMES EARL RAY		44. SIGNATURE OF JURY JAMES EARL RAY		45. SIGNATURE OF JURY JAMES EARL RAY	
46. SIGNATURE OF JURY JAMES EARL RAY		47. SIGNATURE OF JURY JAMES EARL RAY		48. SIGNATURE OF JURY JAMES EARL RAY	
49. SIGNATURE OF JURY JAMES EARL RAY		50. SIGNATURE OF JURY JAMES EARL RAY		51. SIGNATURE OF JURY JAMES EARL RAY	
52. SIGNATURE OF JURY JAMES EARL RAY		53. SIGNATURE OF JURY JAMES EARL RAY		54. SIGNATURE OF JURY JAMES EARL RAY	
55. SIGNATURE OF JURY JAMES EARL RAY		56. SIGNATURE OF JURY JAMES EARL RAY		57. SIGNATURE OF JURY JAMES EARL RAY	
58. SIGNATURE OF JURY JAMES EARL RAY		59. SIGNATURE OF JURY JAMES EARL RAY		60. SIGNATURE OF JURY JAMES EARL RAY	
61. SIGNATURE OF JURY JAMES EARL RAY		62. SIGNATURE OF JURY JAMES EARL RAY		63. SIGNATURE OF JURY JAMES EARL RAY	
64. SIGNATURE OF JURY JAMES EARL RAY		65. SIGNATURE OF JURY JAMES EARL RAY		66. SIGNATURE OF JURY JAMES EARL RAY	
67. SIGNATURE OF JURY JAMES EARL RAY		68. SIGNATURE OF JURY JAMES EARL RAY		69. SIGNATURE OF JURY JAMES EARL RAY	
70. SIGNATURE OF JURY JAMES EARL RAY		71. SIGNATURE OF JURY JAMES EARL RAY		72. SIGNATURE OF JURY JAMES EARL RAY	
73. SIGNATURE OF JURY JAMES EARL RAY		74. SIGNATURE OF JURY JAMES EARL RAY		75. SIGNATURE OF JURY JAMES EARL RAY	
76. SIGNATURE OF JURY JAMES EARL RAY		77. SIGNATURE OF JURY JAMES EARL RAY		78. SIGNATURE OF JURY JAMES EARL RAY	
79. SIGNATURE OF JURY JAMES EARL RAY		80. SIGNATURE OF JURY JAMES EARL RAY		81. SIGNATURE OF JURY JAMES EARL RAY	
82. SIGNATURE OF JURY JAMES EARL RAY		83. SIGNATURE OF JURY JAMES EARL RAY		84. SIGNATURE OF JURY JAMES EARL RAY	
85. SIGNATURE OF JURY JAMES EARL RAY		86. SIGNATURE OF JURY JAMES EARL RAY		87. SIGNATURE OF JURY JAMES EARL RAY	
88. SIGNATURE OF JURY JAMES EARL RAY		89. SIGNATURE OF JURY JAMES EARL RAY		90. SIGNATURE OF JURY JAMES EARL RAY	
91. SIGNATURE OF JURY JAMES EARL RAY		92. SIGNATURE OF JURY JAMES EARL RAY		93. SIGNATURE OF JURY JAMES EARL RAY	
94. SIGNATURE OF JURY JAMES EARL RAY		95. SIGNATURE OF JURY JAMES EARL RAY		96. SIGNATURE OF JURY JAMES EARL RAY	
97. SIGNATURE OF JURY JAMES EARL RAY		98. SIGNATURE OF JURY JAMES EARL RAY		99. SIGNATURE OF JURY JAMES EARL RAY	
100. SIGNATURE OF JURY JAMES EARL RAY		101. SIGNATURE OF JURY JAMES EARL RAY		102. SIGNATURE OF JURY JAMES EARL RAY	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8665

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08663

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN lb <b>24 DAYS</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>E.</b> Last <b>SPIDEL</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>17</b> Year <b>19 60</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 18, 1877</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Blacksmith Railroad</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
11. FATHER'S NAME <b>HENRY SPIDEL</b>			14. MOTHER'S MAIDEN NAME <b>Susan PINE</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC MMOCARDITIS</b> <b>420-1</b> DUE TO <b>CORONARY ARTERY DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b> <b>-----</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>7-26</b> 19 <b>60</b> to <b>7-17</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>7-16</b> 19 <b>60</b> , and that death occurred at <b>2:15 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <i>William P. James</i>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>DR. W.P. JAMES</b>			22d. ADDRESS <b>4414 Center St, Cumberland, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-19-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scarpelli Funeral Home</b>			25a. REC'D BY REGISTRAR DATE <b>AUG 23 '60</b>		
ADDRESS <b>Cumberland, Md</b>			25b. REGISTRAR'S SIGNATURE <i>Arthur J. Kinn</i>		

88088

CERTIFICATE OF DEATH

88088

ALLIANCE HOSPITAL

CONFERRED

ON DAYS

GENERAL HOSPITAL

CLARENCE E. BRIDEL

WHITE

RETIRED

HENRY BRIDEL

MINNIE K. BRIDEL

CHRONIC MYOCARDITIS

CHRONIC MYOCARDITIS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08664

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HSOPITAL</b>		d. STREET ADDRESS <b>13 RICHARD WAY</b>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>UGHI</b> Last <b>UGHI</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>10</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 15, 1876</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>Naturalized</b>	
13. FATHER'S NAME <b>GERALD SCQUELLA (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>NICOLETTA ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Mrs. Edward Robson, LaVale, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-7-60</b> to <b>8-10-60</b> , that (I) (we) last saw the deceased alive on <b>8-10-60</b> and that death occurred at <b>8:15 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. Kins</b>		22b. DATE SIGNED <b>8:15 AM</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 13, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 15 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles L. Kins</b>			

03030

OFFICE OF THE ATTORNEY GENERAL

June 1908

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TO THE HONORABLE THE ATTORNEY GENERAL

FROM

NO.

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IN

THE

OFFICE

OF

THE

ATTORNEY

General, Department of Justice, Washington, D.C.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8667 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08665

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D. O. A. Memorial Hosp.</b>		d. STREET ADDRESS <b>2 Utah Ave.,</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>DRAUDY</b> Last <b>WEBB</b>		4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1895</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Nicholas Co. W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Webb</b>		14. MOTHER'S MAIDEN NAME <b>Dora Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>217-10-5391</b>	
17. INFORMANT <b>Mr. Aubrey V. Webb</b>		Address <b>4 Utah Ave., Cumb. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS WITH THROMBOSIS</b> DUE TO (c) <b>---</b>			INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>August 23, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/26/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Arund</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8668 CERTIFICATE OF DEATH 08666

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>1/18/55</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>G. D.</b> Last <b>Weber</b>				4. DATE OF DEATH Month <b>August</b> Day <b>6,</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/25/1879</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>August Quantz</b>				14. MOTHER'S MAIDEN NAME <b>Anna Catherine Schaidt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>P.O. Box 599</b> Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis,</b> DUE TO (c) <b>Coronary sclerosis,</b>				INTERVAL BETWEEN ONSET AND DEATH ? ? ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe Dehydration.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1/18/55</b> to <b>8/6/60</b> , that (I) (we) last saw the deceased alive on <b>8/6/60</b> , and that death occurred on <b>8/6/60</b> at <b>8:55 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James E. McLean</b>				22b. DATE SIGNED <b>8/8/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>				22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 9, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 10 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8669

CERTIFICATE OF DEATH

08667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland.</b>				c. LENGTH OF STAY IN 1b <b>02</b> <b>Cumberland.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>632 N. Centre St.,</b>				d. STREET ADDRESS <b>632 N. Centre St.,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>PEARL</b> Last <b>WEISENMILLER</b>				4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 19, 1894</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.		IF UNDER 24 HRS. Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Bedford Co. Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William Twigg</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Leasure</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Raymond Thompson P. O. Box 205</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the bladder</b> DUE TO <b>181.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>57 Greene St.,</b>				20g. (County) <b>Cumberland, Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>1-3-1960</b> to <b>8-1-1960</b> , that I last saw the deceased alive on <b>7-30-1960</b> , and that death occurred at <b>10:05 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Greene St.,</b> DATE SIGNED <b>L Brings</b>							
ACTUAL SIGNATURE <b>L Brings</b>				PHYSICIAN'S NAME (Type) <b>Lewis Brings M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8/4/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>				22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>				24c. (City or town) <b>Cumberland, Md.</b>		24d. (State) <b>Md.</b>	



# EXTRA BOND





CERTIFICATE OF DEATH

100-1000

<p>NAME OF DECEASED <i>William B. Smith</i></p>		<p>AGE <i>65</i></p>	
<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF DEATH <i>Jan 15 1910</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>PREVAILING DISEASE <i>Arteriosclerosis</i></p>		<p>PREVAILING SYMPTOMS <i>Angina Pectoris</i></p>	
<p>DATE OF BIRTH <i>Jan 15 1845</i></p>		<p>PLACE OF BIRTH <i>Massachusetts</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>RELIGION <i>Protestant</i></p>		<p>MARRIAGE <i>Married</i></p>	
<p>DATE OF MARRIAGE <i>Jan 15 1870</i></p>		<p>NAME OF SPOUSE <i>John A. Smith</i></p>	
<p>DATE OF INTERMENT <i>Jan 17 1910</i></p>		<p>PLACE OF INTERMENT <i>Cemetery</i></p>	
<p>NAME OF MINISTER <i>Rev. J. H. Jones</i></p>		<p>NAME OF CLERGYMAN <i>Rev. J. H. Jones</i></p>	
<p>NAME OF FUNERAL HOME <i>John A. Smith</i></p>		<p>NAME OF UNDERTAKER <i>John A. Smith</i></p>	
<p>NAME OF BURIAL PLACE <i>John A. Smith</i></p>		<p>NAME OF CEMETERY <i>John A. Smith</i></p>	
<p>NAME OF CITY <i>Boston</i></p>		<p>NAME OF COUNTY <i>Suffolk</i></p>	
<p>NAME OF STATE <i>Massachusetts</i></p>		<p>NAME OF COUNTRY <i>United States</i></p>	

100-1000

100-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08669

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		c. LENGTH OF STAY IN 1b <b>10 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>		d. STREET ADDRESS <b>323 CUMBERLAND STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AMANDA</b> Middle <b>L.</b> Last <b>WILLISON</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>15</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 30, 1870</b>
9. AGE (In years lost birthday) <b>90</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WESLEY BENNETT</b>		14. MOTHER'S MAIDEN NAME <b>Rx REBECCA PERDEW</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <del>and</del> unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Advanced cerebral arterio</b> DUE TO <b>Infirmitie's of age.</b> (c) <b>Sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>10 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>12-15-55</b> to <b>8-15-60</b> that (I) <del>was</del> last saw the deceased alive on <b>8-14-1960</b> and that death occurred at <b>2:45 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. F. Williams</b>		22b. DATE SIGNED <b>8-15-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>		22d. ADDRESS <b>122 SO. CENTRE STREET, CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 17, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Mausoleum</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc.</b>		25a. REC'D BY REGISTRAR <b>AUG 17 '60</b>	
ADDRESS <b>Cumberland, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>	

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STATE OF OHIO

881

ALLEGANY

WILLIAM

ALLEGANY

GREENLAND

10 DAYS

GREENLAND

257 GREENLAND STREET

WILLIAM & JEROME HOSPITAL

ABOUT

WILLIAM

WILLIAM

MAY 20, 1920

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WHITE

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REYNOLDS

HOSPITAL HOSPITAL, GREENLAND, NO.

*[Faint, illegible handwritten text]*

152 00, CENTRE STREET, GREENLAND, NO.

MR. W. J. WILLIAM

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8691

08670

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRANKLIN</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BOX 29, RD 1, WESTERNPORT</b>				d. STREET ADDRESS <b>BOX 29, RD 1, WESTERNPORT</b>			
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>AUGUSTUS</b> Middle <b>WINKLER</b> Last				4. DATE OF DEATH Month <b>AUG.</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 21, 1885</b>		9. AGE (In years last birthday) <b>74</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BLACKSMITH</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MACHINE SHOP</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN WINKLER</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE BARNHOUSE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-07-7240</b>		17. INFORMANT Address <b>Mrs. Winkler, Box 29, RD 1, Westernport, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Atherosclerotic heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 15, 1960</b> to <b>August 5, 1960</b> , that (I) (we) last saw the deceased alive on <b>Aug 4, 1960</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>William W. Lesh</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/5/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>William W. Lesh, M. D.</b>				22d. ADDRESS <b>84 Main St., Westernport, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Aug 7, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elizbeth</b> ADDRESS <b>Westernport, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>	

BP

08630

CERTIFICATE OF DEATH

8630

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1  
M  
8679  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <i>Alleg.</i> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; if not, give address before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3V01-4</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>				d. STREET ADDRESS <b>3800 Ravenwood Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>Elizabeth</b> Last <b>Yuhaniak</b>				4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 31, 1921</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>60</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Continental can</b>		11. BIRTHPLACE (State or foreign country) <b>Frostburg, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry T Stafford</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Wenck</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>John J. Yuhaniak</b>		17. INFORMANT <b>3829 Ravenwood Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot of head</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Aspiration of blood</b> DUE TO (b) <b>781x</b> (c) <b>XXXX</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot during altercation</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot during altercation</b>			
20c. TIME OF INJURY Month, Day, Year <b>abt. 1:30 A.M. 8/19/60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>New Germany Barrett Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>				DATE SIGNED <b>8/20/60</b>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>Aug. 23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>	
23. FUNERAL DIRECTOR <b>Leonard J. Ruck</b>				22d. LOCATION (City, town, or country) (State) <b>Elkridge Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 24 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>							

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IN LINE



3000 Hawthorn Avenue

Hawthorn Hospital

August 12, 1932

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Aug 21, 1932

Female - white

Contraceptive cor

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